

**Commonwealth of Kentucky
Personnel Cabinet
Department for Employee Insurance**

2007 Dependent Add Form

This form must be used for any qualifying event (QE) that allows you to add dependents to your plan. *Complete a Health Insurance Application for election changes such as option changes, new coverage, new waiver or to begin a cross-reference plan.*

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Applicant's SSN

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Retiree's SSN (if applicable)

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Company Number

Print Name (First, MI, Last) _____

To be eligible to add a dependent to your health insurance plan, you must certify that you have experienced the QE as listed here →
The QEs listed on this form are the only events that allow you to ADD dependents to your plan. To be considered an eligible dependent, your dependent MUST meet one of the conditions below:

- ☐ Your Legal Spouse; or
- ☐ Your unmarried child, stepchild, foster child or other child that will be under age 24 in the current plan year, and depends on the employee for more than 50% of his/her support and maintenance and lives in the household in a parent-child relationship.
(Exception: Court Orders and Administrative orders to provide health coverage for the child.)

NOTE: EFFECTIVE DATE FOR COVERAGE IS 1ST DAY OF THE FOLLOWING MONTH FROM MEMBER'S SIGNATURE DATE ON ADD FORM, except for Birth, Birth plus, Adoption/Placement and placement for Adoption, which are effective on the date of the event, and National Medical Support Notice 1st day of the month after notice date.

Qualifying Events: (Check one)

- ☐ Birth newborn only (60 days)
- ☐ Birth plus other dependents (30 days)
- ☐ Adoption*/ Placement for Adoption* (60 days)
- ☐ Adoption*/ Placement for Adoption* plus other dependents (30 days)
- ☐ Legal guardianship*, Administrative Order* or court order* pertaining to health insurance+
- ☐ Marriage
- ☐ Sp/Retiree has different Open Enrollment period*+
- ☐ Sp/Dep loses other coverage*
- ☐ Sp/Dep loses governmental group coverage*
- ☐ Dependent Care FSA significant cost increase
- ☐ Unmarried dependent re-establishes eligibility* (member must supply information on reason to re-establish eligibility)
- ☐ Other _____

Qualifying Event Date (mm/dd/yy): _____

Note: SP = Spouse DEP = Dependent

** Supporting documentation required +Refer to QE chart for redirection rules*

PRINT the following information for each dependent to be added:

Social Security Number	Name (First, MI, Last)	Gender (Circle One)	Date of Birth	Rel. Code **
		M F		
		M F		
		M F		
		M F		

** Rel. Code: SP = Spouse / CH = Child / CO = Court Ordered Dependent / DD = Disabled Dependent

If your employer does not participate in Commonwealth Choice, contact your Insurance Coordinator for specific information. Retirees are not eligible to participate in an FSA.

Healthcare FSA

I request to change my annual election
from \$_____ per year to \$_____ per year.

Dependent Care FSA

I request to change my annual election
from \$_____ per year to \$_____ per year.

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

Applicant Signature

Date

Insurance Coordinator Signature

Date

Signatures are required below if changes to an existing cross-reference plan are being requested

Spouse Signature

Date

Spouse Insurance Coordinator Signature

Date